Office-Supreme Court, U.S.
FILED
JUL 31 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-1429

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

DUANE YOUNGBERG, *et al.*,
Petitioners

v.

NICHOLAS ROMEO, an incompetent, by his Mother and Next Friend, PAULA ROMEO,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Psychiatric Association (APA) was founded in 1844 and is the Nation's largest organization of qualified doctors of medicine specializing in psychiatry. Twenty-six thousand of the Nation's approximately 33,000 psychiatrists are members. Many psychiatrists work in mental facilities and psychiatrists generally bear a major responsibility for evaluating, developing programs for, and caring for the mentally-retarded. The APA has established a special commission dealing with problems of the mentally-retarded and has issued position papers relating to their care and treatment.

The APA has previously participated as *amicus curiae* in numerous cases involving mental health issues. See *Pennhurst State School and Hospital* v. *Halderman*, 49 U.S.L.W. 4363 (April 20, 1981); *Parham* v. *J.R.*, 442 U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). The present case involves signficant issues regarding care of, and responsibility for, the mentally-retarded, including the establishment of constitutional standards for care and treatment and the likely imposition of personal liability on individuals unable to correct institutional inadequacies. The APA believes that its clinical experience and insight concerning the mentally-retarded can assist the Court in addressing the important issues in this case.

The parties have consented to the filing of this brief. Their letters are being filed with the Clerk of this Court.

SUMMARY OF ARGUMENT

It is the position of the American Psychiatric Association that, having committed the mentally-retarded, the states must provide them with adequate habilitation and decent care. Although the fact of confinement imposes significant restrictions on individual liberty, due process nevertheless requires the states to take reasonable steps to protect remaining liberty interests where the intrusion on state interests is not substantial. See *Wolff* v. *McDonnell*, 418 U.S. 539 (1974); pages 4-10 *infra*. Due process also requires the states to correct conditions of continuous hardship and deprivation. See *Bell* v. *Wolfish*, 441 U.S. 520 (1979); pages 10-14 *infra*.

We do not believe, however, that the states, in choosing among acceptable treatments and restraints, must also meet standards of compelling necessity or the least restrictive alternative. Although the Third Circuit, relying on cases in very different contexts, sought to make the existence of less restrictive alternatives controlling on clinical judgments, the existence of such alternatives should be only one factor in determining whether the

states have met basic standards of adequacy or decency. See pages 15-22 *infra*. This approach not only makes constitutional sense but more closely approximates the reality of habilitation in a mental facility, where patients reside in part because their capacity to cope with freedom is different from that of other persons. See pages 22-23 *infra*.

The decision below also raises the likelihood of individual liability for institutional failings. When the Constitution requires affirmative action by the states, and state officials cannot take that action by themselves, there is no justification for making the officials answerable in damages. To avoid this inequitable result, this Court should make clear either that individuals are not liable for constitutional torts without fault or that the defense of good faith immunity encompasses good faith efforts to satisfy constitutional standards. See pages 24-26 *infra*.

ARGUMENT

I. THE DUE PROCESS CLAUSE REQUIRES STATES TO PROVIDE RETARDED PERSONS WHO ARE INVOLUNTARILY COMMITTED WITH ADEQUATE HABILITATION AND DECENT CARE.

The due process clause, unlike the free speech clause, does not purport to speak in absolutes. The language of the clause itself indicates that states may deprive persons of liberty or property, or even life, provided that notions of due process are satisfied. But, to assure that these deprivations serve legitimate state ends, the due process clause imposes both procedural and substantive limitations on state action. See, e.g., *Parham* v. *J.R.*, 442 U.S. 584 (1979) (inquiry by neutral fact finder needed to protect children against improper commitment); *Addington* v. *Texas*, 441 U.S. 418 (1979) (clear and convincing evidence required for involuntary commitment); *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975)

(state cannot provide custodial care to nondangerous individual capable of surviving without commitment). The more important the interest at stake, the more significant the limitations must be. See *Addington* v. *Texas*, *supra*, 441 U.S. at 423.

Having been involuntarily deprived of their liberty, the mentally-retarded have substantial interests in receiving adequate habilitation and decent care.[1] A lack of habilitation not only deprives committed persons of any chance to regain their freedom but makes the confinement itself little more than a custodial detention. The absence of decent care, of course, can cause severe physical and mental hardship over an extended period of time, as well as defeat the prospects for beneficial habilitation. These interests are thus at the core of life itself for the mentally retarded.

By contrast, the states can claim no overriding interest in withholding proper habilitation and care. The provision of adequate habilitation and care does not interfere with professional or administrative discretion, since the failure to provide such treatment arises from lack of funding not professional judgment. Although the states have a legitimate interest in restraining the cost of their programs, that interest must ultimately yield to the interest in having acceptable conditions for the involuntarily-committed mentally retarded.

A. Adequate Habilitation.

It is well-recognized that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." *Addington* v.

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[1] The word "habilitation," rather than "treatment," is commonly used to refer to programs for the mentally-retarded because mental retardation is considered to be essentially a learning disability and training impairment rather than an illness. While psychiatric treatment may comprise part of a program for the mentally-retarded, the principal focus of habilitation is upon training and development of needed skills.

Texas, supra, 441 U.S. at 425. See *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Although this Court has acknowledged that the states have a legitimate interest in confining persons found dangerous to others or unable to care for themselves, it has also taken pains to assure that individual liberty is not unnecessarily withdrawn. See *Addington* v. *Texas, supra; O'Connor* v. *Donaldson, supra*. Thus, the Court has said that all persons have "a substantial liberty interest in not being confined unnecessarily for medical treatment . . ." *Parham* v. *J.R., supra*, 442 U.S. at 600.

We believe that the mentally retarded also have a substantial liberty interest in not being confined *without* treatment. While the rights of the involuntarily committed "may be diminished by the needs and exigencies of the institutional environment," *Wolff* v. *McDonnell*, 418 U.S. 539, 555 (1974), that does not mean that committed persons are "wholly stripped of constitutional protections." *Ibid.* Rather, as the Court indicated in *Wolff*, their liberty interests must be weighed against "restrictions imposed by the nature of the regime to which they have been lawfully committed." *Id.* at 556. In the final analysis, "there must be mutual accommodation between the institutional needs and objectives and the provisions of the Constitution that are of general application." *Ibid.*

The failure to provide adequate habilitation to the mentally retarded deprives them of liberty in a very real sense. For many, of course, the lack of habilitation will deny them their only real chance to regain their freedom, since mental retardation does not lessen all by itself. Habilitation is essential if retarded persons are to develop needed skills and assume greater responsibility for their own care, improvements that are necessary for the retarded to live independently or with the help of family or friends. See M. Rosen, *et al., Habilitation of the Handicapped*, 115 *et seq.* (1977); W. Wolfensberger,

The Principle of Normalization in Human Services (NIMH 1977); Pres. Comm. on Mental Retardation, *Mental Retardation: The Leading Edge* (1978). See generally Roos, *The Law and Mentally-Retarded People: An Uncertain Future*, 31 Stan. L. Rev. 613 (1979). Thus, although committed residents might otherwise become entitled to release as their need for care diminished, see *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 575, inadequate habilitation may effectively convert a temporary confinement to a permanent one.

Even if habilitation does not lead to eventual release, it can greatly increase the liberty achievable within the institution itself. It is as true in confinement as without that "[o]ne who is suffering from a debilitating mental illness and in need of treatment is [not] wholly at liberty . . ." *Addington* v. *Texas*, *supra*, 441 U.S. at 429. Adequate habilitation will lessen the dependency of retarded residents, allowing them to do more for themselves and to relate to other residents. At the very least, it will diminish the chance that the effects of retardation will be made worse by commitment. See Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Law. 138, 146 *et seq.* (1972). The difference between the capacity to do things for oneself and the fate of total dependency is as much personal liberty as many mentally retarded people will ever know.

It is inherent in the nature of involuntary commitment that the confined resident must rely on the state to help him with his disability. In other circumstances, this Court has held that the states have an "obligation to provide medical care for those whom [they are] punishing by incarceration." *Estelle* v. *Gamble*, 429 U.S. 97 (1976).[2] The Court noted there that this obligation arises

[2] Although the standard adopted by the Court under the cruel and unusual punishment clause requires a showing of "deliberate indifference to serious medical needs," 429 U.S. at 106, we believe

from the fact of enforced dependence, observing that the incarcerated person "must rely on [the] authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met." *Id.* at 103. The Court then stated: "[I]t is but just that the public be required to care for the [individual], who cannot by reason of the deprivation of his liberty, care for himself." *Id.* at 104, quoting *Spicer* v. *Williamson*, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926) (internal quotation marks omitted).

This reasoning applies with ever greater force in the context of involuntary commitment. Not only is the retarded resident dependent on the state to meet his habilitation needs, but it is his disability that has led to commitment in the first instance. And the loss of skills, or other deterioration resulting from the failure to give habilitation, can cause pain and suffering every bit as real as the pain and suffering caused by an injured limb. See *Estelle* v. *Gamble*, *supra*, 429 U.S. at 103. Unless the Constitution is to be read to protect only bones and joints, these interests must be considered important as well.

We also think it significant that the states do not seek to commit all needy persons or all persons posing a danger to others. Rather, they have singled out the mentally-retarded (and the mentally-ill) for commitment on the basis of their particular conditions. See, e.g., 50 Pa. Stat. § 4406 (authorizing involuntary commitment of persons "mentally disabled and in need of care or treatment by reason of such mental disability").[3] Having made that

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that standard to be too severe in situations where no punishment at all is permissible. Since the mentally-retarded are confined through no fault of their own, the states should bear an affirmative obligation to give persons in involuntary custody adequate medical care. See pages 10-14, *infra*.

[3] The standards for commitment vary somewhat from state to state. In general, however, they authorize commitment upon a showing of mental retardation or mental disability and the need

distinction, however, the states should not be free to ignore it in setting the conditions of confinement. "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Jackson* v. *Indiana*, 406 U.S. 715, 768 (1972).

We can discern no reasonable relation between the decision to make mental retardation an essential element of commitment itself and the decision to make it meaningless after commitment. The only rationale for confining the mentally-retarded, while not confining others who may be dangerous or unable to care for themselves, is the belief that mental retardation can be the subject of at least some habilitation, which in turn will assist the retarded person to care for himself.[4] That rationale fails, of course, if no habilitation is provided. Under those circumstances, commitment is no more than preventive detention without any connection to the condition underlying commitment in the first place. Although the Court has indicated that a state may treat what it cannot punish, see *Robinson* v. *California*, 370 U.S. 660 (1962),[5] it

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for care and/or treatment. A few statutes allow commitment of the mentally retarded if they are shown to be a danger to others. See generally, P. Friedman, *The Rights of the Mentally-Retarded* 33-34 (1976); S. Brakel and R. Rock, eds., *The Mentally Disabled and the Law* 34 *et seq.* (rev. ed. 1971).

[4] The basis for this distinction does not depend on whether the state is exercising its police power or its *parens patriae* power in making the commitment. Whatever power the state is using, it elects to use it not against the general population, but against the specific population of the mentally-retarded. The fact of mental retardation is thus a necessary element of every commitment, regardless of what the additional factors supporting commitment might be.

[5] The Court in *Robinson*, when dealing with narcotics addicts, went on to indicate that a state might subject persons suffering from mental illness or other afflictions to "compulsory treatment, involving quarantine, confinement, or sequestration." 370 U.S. at

has never suggested that a state may simply detain what it will not treat.[6]

While recognition of a right to habilitation may cause some states to expend additional funds, it will not otherwise interfere with important state interests. In particular, it will not interfere with professional discretion, for no one suggests that a lack of habilitation is positively desirable. Compare *Bell* v. *Wolfish*, 441 U.S. 520, 537-40, 545-48 (1979); *Rizzo* v. *Goode*, 423 U.S. 362, 377-78 (1976). Nor do we see any likelihood that it will disrupt efficient management of mental facilities. Unlike notions of compelling necessity or least restrictive alternative, which we discuss below, the idea of adequate habilitation does not force (or allow) courts to second-guess legitimate medical or administrative decisions on the ground that some other decision might have been preferable. It simply provides that, where important liberty interests can be enhanced without limiting the states' administrative or professional discretion, then the states must make reasonable efforts to do so.[7]

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666. But it is a very different matter to say that a state may enforce compulsory sequestration *without* treatment. Indeed, it would be illogical to prohibit a state from confining someone for 90 days for the "criminal offense" of being a narcotics addict but allow it to confine someone forever for that condition without making any effort to treat the person or help him regain his liberty.

[6] To our knowledge, every federal court to consider the issue has ruled that committed mentally-retarded and mentally-ill patients have a constitutional right to treatment or habilitation. See, e.g., *Wyatt* v. *Aderholt*, 503 F. 2d 1305 (5th Cir. 1974); *Gary W.* v. *Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and vacated and remanded in part on other grounds*, 550 F. 2d 1122 (8th Cir. 1977). See generally Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190 (1974).

[7] This Court has rejected the notion that courts are incompetent to make a limited inquiry into whether adequate treatment is being provided. See *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 574 n. 10. See also *Rone* v. *Fireman*, 473 F. Supp. 92 (E.D. Ohio 1979).

The fiscal concerns of the states are, of course, significant ones. It will do little to help the mentally-retarded if standards are set so unrealistically that states simply leave retarded persons to fend for themselves rather than care for them at all. It is important, therefore, for reviewing courts to remember that public facilities cannot always provide ideal levels of care and that exaggerated demands on state resources for some persons may cause a denial of benefits for other needy people. But, in our view, the risk of occasional judicial excess is an acceptable price of assuring that involuntary commitment of the retarded is something more than a benign seclusion.

B. Decent Care.

It is obvious that efforts to provide adequate habilitation depend in large part on the decency of the immediate surroundings. A retarded person suffering from lack of food or sanitary living conditions, or living in constant fear of physical harm, can hardly be expected to benefit much from his habilitation program. It stands to reason, therefore, that an adequate environment for habilitation is as much a part of the right to habilitation as the habilitation program itself. See, e.g., *Wyatt* v. *Aderholt*, *supra*, 503 F.2d at 1313.

The duty to provide decent care does not depend solely upon the right to habilitation, however, for the Court has recently made clear that the due process clause imposes substantive limits on treatment of persons not convicted of any crime. See *Bell* v. *Wolfish*, *supra*, 441 U.S. at 533. Taking its cue from *Ingraham* v. *Wright*, 430 U.S. 651 (1977), a case in which it had refused to apply the cruel and unusual punishment clause to the administration of school discipline, the Court has established that "freedom from punishment [is] within the liberty of which no person may be deprived without due process of law." *Id.* at 535-36 n.17.[8] In this regard, the Court recognized that

[8] This test appears to derive from a similar, though presumably less stringent inquiry, in cases challenging prison conditions under

forcing persons "to endure genuine deprivations and hardship over an extended period of time might raise serious questions under the Due Process Clause as to whether those conditions amounted to punishment. . . ." *Id.* at 542. Alternatively, the Court noted that "if a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court may permissibly infer that the purpose of the governmental action is punishment. . . ." *Id.* at 539.

Even giving all necessary deference to state officials (*id.* at 540-541 n. 23), therefore, the courts may properly examine conditions in state institutions to determine if they cause sustained privations and hardship or if they are unrelated to any legitimate goal. This inquiry is particularly appropriate in the case of state facilities for the mentally-retarded. If unsanitary facilities or inadequate food or protection may constitute cruel and unusual punishment, or punishment of any sort, the states have no reason whatsoever to inflict them on the mentally-retarded. As this Court has noted, "[i]n a civil commitment state power is not exercised in a punitive sense." *Addington* v. *Texas*, *supra*, 441 U.S. at 428.

We do not mean to draw too close an analogy between mental facilities and prisons: at times such facilities have been too much like prisons, not too litle. It must be remembered that the very purpose of a mental facility is to provide care for persons usually unable to care for

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the cruel and unusual punishment clause. Even though states have a legitimate interest in punishing persons convicted of crimes, the Court has emphasized that the interest does not stretch so far as to allow "serious deprivations of basic human needs" or denial of "the minimal civilized measure of life's necessities." *Rhodes* v. *Chapman*, 49 U.S.L.W. 4677, 4679 (June 15, 1981). The Court has also acknowledged that fears about such conditions, at least in prisons, are not fanciful, remarking that "conditions in a number of prisons, especially older ones, have been justly described as 'deplorable' and 'sordid'." *Id.* at 4680, quoting *Bell* v. *Wolfish*, *supra*, 441 U.S. at 539.

themselves. See *Schweiker* v. *Wilson*, 101 S. Ct. 1074, 1087 n. 3 (1981) (Powell, J., dissenting) ("a mental hospital is not a penal institution"). By definition, therefore, decent care is essential to the fulfillment of the state's interest in commitment. State prisons or detention facilities, on the other hand, serve the principal purpose of punishing inmates or assuring their attendance at trial, objectives to which the provision of care is simply an ancillary part. The adequacy of the conditions thus must be viewed with an eye to the nature and purpose of the institution involved.

It is also important to remember that the interests of the mentally-retarded are very different from the interests of other persons held in custody by the states. To begin with, involuntarily-committed persons have not been deprived of their liberty through any crime or fault of their own (as have convicted prisoners), or even through any preliminary findings of crime or fault (as have pretrial detainees). They have been confined solely because of a condition beyond their control and a demonstrated inability to cope with the incidents of freedom. Moreover, the retarded have an affirmative interest in receiving habilitation, an interest that can be severely undermined by inadequate conditions. See page 10 *supra*. And, even more importantly, confinement of the mentally-retarded may amount to a life sentence, causing the effects of any deprivations to be multiplied over the course of the confinement.[9] Some involuntarily-committed residents can never expect to have nourishing food or clean, sanitary facilities unless the state provides them.[10]

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[9] At Pennhurst, the average residency is twenty-one years. See *Halderman* v. *Pennhurst State School & Hospital*, 446 F. Supp. 1295, 1302 (E.D.Pa. 1978).

[10] The length of possible confinement strongly differentiates the mentally-retarded from pretrial detainees. In *Bell* v. *Wolfish*, for example, the Court noted that "[n]early all of the detainees are released within 60 days." 441 U.S. at 543. By definition, pretrial

Although the precise dimensions of proper care are not easy to define, and are better left for resolution in case-by-case fashion, they should include at least decent food, living conditions, clothing, medical attention, and protection from physical injury. See generally *Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded*, 134 Am. J. Psychiat. 354 (1977).[11] Whether intended as punishment or not, a knowing denial of these essentials over an extended period of time would constitute a genuine hardship to retarded residents.[12] It cannot be doubted that retarded persons have real and substantial interests in living in adequate surroundings, eating nourishing food, receiving medical care, and living without needless fear. For the retarded, as for the non-retarded, those interests are the ingredients of a meaningful life.[13]

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detention facilities are *temporary* residences where the adverse effects of poor conditions are minimized by the brevity of the stay. For the mentally-retarded, however, the impact of inadequate food or protection may have no limit at all, consigning them to a lifetime of physical deprivation.

[11] As we discuss *infra*, a state need not justify any failure to provide protection by a standard of "substantial necessity." In our view, that standard cuts too deeply into clinical decisions about appropriate placements for individual residents. But state officials must demonstrate that, within the bounds of recognized programs, they have taken reasonable steps to eliminate unnecessary risks of harm.

[12] It may be assumed that occasional breakdowns and mishaps will result in any institutional setting. These temporary, inadvertent lapses would not seem to rise to the level of a violation of due process.

[13] Although there are persons outside of state custody who lack adequate living conditions and other essentials, we do not think that the state may consign the mentally-retarded to a miserable standard of living merely because they or other persons might suffer in the same way on the streets. Persons outside institutions at least are not totally dependent on state care and may find help from other sources, a chance denied to the involuntarily committed. See pages 6-7 *supra*. Moreover, this lowest-common-denominator

We see no reason to give particular deference to state officials in these matters. No official can reasonably claim that he is providing unventilated rooms, or inadequate toilet facilities, or revolting food because his professional judgment recommends it. Nor are such conditions reasonably related to the goals of helping the mentally-retarded or maintaining order within the institution.[14] If anything, the existence of such conditions affirmatively works against legitimate goals, by discouraging voluntary confinement, creating obstacles to habilitation, and stimulating disorder. The failure to provide decent conditions thus results only from an unwillingness or inability to meet basic standards, not from an exercise of professional discretion.

Nor is it a sufficient answer to suggest that fiscal concerns should be held paramount. While significant, see p. 10 *supra*, these concerns must give way to the need to assure that basic human needs are met. Having authorized involuntary commitment of the mentally-retarded, the states cannot then decide that decency is a luxury they cannot afford. In the end, it is better to have no commitment at all than a system of commitment through which the states neglect or abuse their citizens.[15]

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theory would operate as the mirror image of "least restrictive alternative" analysis, establishing the lowest possible threshold rather than the highest possible one.

[14] In the case of prisons, at least, states may have an affirmative interest in seeing that the surroundings convey a spartan character, assuring that prisoners remember that confinement is in fact punishment. The states have no such interest with regard to a facility for the retarded. The courts thus must make sure that conditions meet a minimum standard for persons who may not be punished at all.

[15] Although the cost of upgrading prisons or detention centers would not be insubstantial, the Court has noted the "deplorable conditions and draconian restrictions of some of our Nation's prisons," adding that "the federal courts rightly have condemned these sordid aspects of our prison systems." *Bell* v. *Wolfish*, *supra*,

II. THE DUE PROCESS CLAUSE DOES NOT REQUIRE STATES TO MEET STANDARDS OF COMPELLING NECESSITY OR THE LEAST RESTRICTIVE ALTERNATIVE.

If the Third Circuit had ordered a new trial for respondent according to standards of decent care and adequate habilitation, we would be in agreement with that decision.[16] But the Court of Appeals went well beyond that point, imposing standards of compelling necessity (for shackling), substantial necessity (for failure to protect from attacks), and the least restrictive alternative (for certain treatment decisions).[17] These standards are unnecessary in constitutional terms and largely inscrutable in clinical terms.

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441 U.S. at 562. It is plain, therefore, that at some point the states must either meet elemental standards or forgo enforced confinement altogether.

[16] We agree with the court of appeals that the district court improperly relied on standards established under the cruel and unusual punishment clause in setting the duty of care and treatment. See *Ingraham* v. *Wright*, 430 U.S. 651, 664-71 (1977).

[17] The court of appeals held that shackling must be justified by a showing of compelling necessity and be the least restrictive alternative; that a failure to provide protection must be justified by a showing of substantial necessity; and that treatments involving a significant deprivation of liberty must be the least intrusive available under the circumstances. Although the decision regarding treatment might be limited to selection of treatment approaches and programs involving surgery or the administration of certain medications, we note that the court of appeals has applied the same analysis to the place of confinement and the right to administer medication without consent in later cases. See page 18, *infra*.

In the discussion that follows, we focus primarily on the standards of compelling necessity and, in particular, the least restrictive alternative. We find no basis, however, for using a standard of "substantial necessity" to evaluate the failure to provide protection, since it requires the courts to decide whether decisions regarding treatment and the placement of residents are not just reasonable and medically appropriate, but substantial as well. That is an injury for which the courts are poorly equipped, particularly when reviewing complicated decisions about maintaining order in an institutional setting.

The doctrine of least restrictive alternative does not travel well from its familiar terrain, see, e.g., *Shelton* v. *Tucker*, 364 U.S. 479 (1960); *Dunn* v. *Blumstein*, 405 U.S. 330 (1972), to the substantive due process area. Although the existence of a less restrictive alternative is a relevant factor in assessing the rationality of any state action, its role as an *independent* basis for striking down state action should be limited to situations, like those involving restraints on First Amendment freedoms, where any state action is considered highly suspect. See, e.g., *Sherbert* v. *Verner*, 374 U.S. 398 (1963). Similarly, the need for a showing of compelling necessity should be confined to cases, such as ones involving distinctions based on race, where the operative presumption is that no state action of the sort is permissible. See, e.g., *Regents of Univ. of California* v. *Bakke*, 438 U.S. 265, 290 (1978) (Powell, J.). In cases based solely on notions of substantive due process, which already tend to involve the risk of substituting judicial preferences for legislative ones (see page 10, *supra*), a resort to the doctrine of least restrictive alternative should be skeptically viewed.

The Third Circuit apparently justified its use of such rigid standards on the ground that shackling, treatment, and protection all involve issues of liberty or bodily security. But, once a state has lawfully confined a person in a hospital or detention facility, it cannot be said that any subsequent actions involving intrusions on liberty or security are presumptively invalid. The very nature of such institutions, even those run in a humane and enlightened fashion, requires affirmative acts and restrictions that would be out of place in society at large. To isolate those acts and restrictions, and then judge them by the strictest standards applicable outside prison or hospital walls, is a constitutional anomaly.

This Court, in fact, has said as much in its recent cases. In *Bell* v. *Wolfish*, *supra*, for example, the Court

refused to invalidate the practice of "double bunking" pretrial detainees despite evidence that overcrowding could be relieved in other ways less intrusive on personal liberty. Noting that the existence of other methods did not mean that the method chosen by the government was unreasonable, the Court remarked: "Government action does not have to be the only alternative or even the best alternative for it to be reasonable, to say nothing of constitutional." *Id.* at 542-43 n.25. Similarly, in *Ingraham* v. *Wright*, *supra*, the Court upheld the practice of administering "reasonable corporal punishment" to schoolchildren, in the face of attacks under the Eighth and Fourteenth Amendments, although "the availability of less severe but equally effective means of discipline" was but one of several factors to be weighed in determining whether the punishment was reasonable. *Id.* at 662.

It is also indicative that, when confronted with an appeal insisting upon a right to placement in the least restrictive environment, this Court dismissed it for want of a substantial federal question. *Sanchez* v. *New Mexico*, 396 U.S. 276 (1970).[18] Although the Third Circuit gave *Sanchez* short shrift, stating that "[t]here have been substantial doctrinal developments since *Sanchez* in the mental health field," it nowhere explains what developments of a constitutional nature make an insubstantial position now compelling. Viewed more realistically, the developments since *Sanchez* show a concern for assuring basic standards of decency without the sort of intrusion on professional discretion that the least restrictive alternative doctrine involves. See pages 16-17 *supra*.

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[18] Although *Sanchez* dealt with the least restrictive alternative issue in the context of the choice of a facility, rather than the choice of a particular treatment, its rationale would control here. If anything, the long-term liberty interests implicated by the choice of a residential placement would seem to be greater than those implicated by a choice among treatments or restraints.

The intrusion on professional judgment in these matters is difficult to overstate. For, just as the constitutional beginnings of "least restrictive" analysis are uncertain, so are its logical ends. Having set the doctrine in motion in *Halderman* v. *Pennhurst State School and Hospital*, 614 F.2d 84 (1979) (en banc), reversed, 49 U.S.L.W. 4363 (April 20, 1981), albeit as a matter of statutory construction there, the Third Circuit has been swept along to hold that particular treatments and shackling must be the least restrictive means available (this case), that the place of confinement must be the least restrictive (*Scott* v. *Plante*, Nos. 80-1314, 1315, 1596 (February 5, 1981), cert. petition pending, No. 80-1699), and that use of medication over objection must be the least restrictive form of treatment possible (*Rennie* v. *Klein*, Nos. 79-2576 and 2577 (July 9, 1981) (en banc)), all as a matter of substantive due process. The fault of this analysis is not that each holding fails to follow from the other, but that they follow all too well, leading the courts to an ever greater role in the selection of a particular treatment, or restraint, or residence, or drug, or dosage, at the expense of other hitherto permissible ones. That is an unfortunate momentum for a theory that never should have gotten started at all.

This Court has repeatedly made clear that judges are not to substitute their own views, in the guise of constitutional edicts, for the reasonable judgments of state officials. In the prison context, for example, the Court has pointed out that "courts are ill-equipped to deal with the increasingly urgent problems of prison administration and reform." *Procunier* v. *Martinez*, 416 U.S. 396, 405 (1974). Although this realistic assessment does not mean that judges should abdicate their role as arbiters of the Constitution, it does mean that, at a minimum, they should remember that "[t]he wide range of 'judgment calls' that meet Constitutional and statutory requirements are confided to officials outside of the Judicial

Branch of Government." *Bell* v. *Wolfish*, *supra*, 441 U.S. at 562.

This note of caution is especially appropriate in the complex fields of mental health and mental retardation. As this Court has recognized, many issues regarding the need for treatment "turn[] on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists." *Addington* v. *Texas*, *supra*, 441 U.S. at 429. It is a simple truth that "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." *Parham* v. *J.R.*, *supra*, 442 U.S. at 607, quoting *In re Roger S.*, 19 Cal. 3d 921, 941 (Clark, J. dissenting) (internal quotation marks omitted). "The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a [patient] is an individual medical decision that must be left to the judgment of physicians in each case." *Id.* at 607-08.

The wisdom of these observations can be readily seen in this case. Although the Third Circuit made a conspicuous effort to separate legal and medical doctrines, it is fanciful to distinguish the shackling and protection issues, described by the court as "undiluted legal concerns," from the treatment issues, said to "entail[] mixed questions of law and medical judgment." Pet. App. 14a. Decisions about restraints and exposure to other residents, matters directly involving the risks and benefits of freedom and social interaction, are frequently made in the context of an overall treatment program. See Rosen *et al.*, *The Role of Physical Restraint in the Treatment of Psychiatric Illness*, 39 J. Clin. Psychiat. 228 (1978); Burstein, *Using Mechanical Restraints on Acutely Disturbed Psychiatric Patients*, 26 Hosp. & Comm. Psychiat. 757 (1975); Soloff, *Physical Restraint and the Nonpsychotic Patient: Clinical and Legal Perspectives*, 40 J. Clin. Psychiat. 302 (1979). Indeed, the

Third Circuit itself recognized (without any apparent effect) that restraints may be part of an acceptable form of therapy, Pet. App. 20a n. 29, and that it may be "therapeutically more desirable to have an admittedly aggressive patient mingling with others instead of confined to an isolated cell." Pet. App. 26a n. 8. See discussion of this issue in Gutheil, *Restraint Versus Treatment: Seclusion as Discussed in the Boston State Hospital Case*, 137 Am. J. Psychiat. 718 (1980); Gair, *Limit-Setting and Seclusion in the Psychiatric Hospital*, Psychiat. Opinion 15 (Feb. 1980); Gutheil, *Observations on the Theoretical Bases for Seclusion of the Psychiatric Inpatient*, 135 Am. J. Psychiat. 325 (1978); Soloff, *Behavioral Precipitants of Restraint in the Modern Milieu*, 19 Comprehen. Psychiat. 179 (1978); Plutchik, *et al.*, *Toward a Rationale for the Seclusion Process*, 166 J. Nervous & Mental Disease 571 (1978). The statement that these are solely legal issues shows quite vividly the problem caused by judges making clinical decisions.

The problem is made worse by the view of the court of appeals regarding treatment. Although the court allows some decisions to be justified as "acceptable . . . in light of present medical or other scientific knowledge," Pet. App. 38a, it goes on to say that any decision involving "significant deprivations of liberty" may be tolerated only if it "provided for the least intrusive treatment available under the circumstances." Pet. App. 47a. The court of appeals thus has forced state physicians to choose a particular mode of treatment (determined after the fact according to an ephemeral "least intrusive" standard) even though another form of treatment would be acceptable or even preferable from a medical standpoint. Indeed, under this doctrine, doctors seemingly will be liable for constitutional torts where they would not be liable for malpractice under state law.

It must be recognized that, while the notion of a least restrictive treatment is superficially enticing, the concept

in practice may be almost unworkable. To begin with, it is not apparent that the least restrictive alternative is always the best from a clinical standpoint, even if treating physicians can figure out what it is. See *Hoffman et al., Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 S. Diego L. Rev. 1100 (1977); Perr, *The Most Beneficial Alternative: A Counterpoint to the Least Restrictive Alternative*, VI Bull. of Am. Ac. of Psychiat. and the Law, No. 4, iv (1978); Bachrach, *Is The Least Restrictive Alternative Always the Best? Sociological and Semantic Implications*, 31 Hosp. & Comm. Psychiat. 97 (1980); Appelbaum, *Least Restrictive Environment: Some Comments, Amplification*, 31 Hosp. & Comm. Psychiat. 420 (1980).[19] Moreover, as a practical matter, it may not be possible to identify the least restrictive alternative at all. It is extremely difficult, for example, to tell whether confinement to a room is more or less restrictive than use of shackles or administration of a drug that permits the resident to remain with other residents in a group situation. The difficulty is made worse by the fact that some treatments may be more intensive but of shorter duration, forcing doctors to balance the restrictiveness of a short-term treatment imposing substantial restraints

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[19] Without identifying any medical basis for its view, the Third Circuit adopted a principle that treatment in state facilities must be risk-averse. Noting that individuals are usually allowed to err on the side of risk, the court nonetheless declared that "[w]hen the state is the decision-maker, the converse would seem appropriate: such actions should err on the side of safety." Pet. App. 32a n. 45. Although safety considerations are part of any medical judgment, see Perr, *The Most Beneficial Alternative: A Counterpoint to the Least Restrictive Alternative*, VI Bull. of Am. Ac. of Psychiat. & the Law No. 4, iv., vii (1978), the decision below would force physicians to elect only the safest treatment for state residents even though more effective treatments would be followed for other retarded persons. The record of a single action for damages is not an adequate basis for so fundamental a reordering of state treatment programs.

against a longer course of treatment with less restraints. Furthermore, the lessening of restrictions for one resident may lead to an increase in restrictions on other residents. To determine a single supposed least restrictive treatment for each resident from this complex of variables is beyond the power of most doctors and, we suspect, most judges as well.

We do not believe that due process requires this sort of judicial second opinion. The existence of a least restrictive alternative is not, nor should it be, the last word in medical decisions; rather, it should be one of numerous factors to be assessed in determining whether state officials have acted in an acceptable fashion. It plainly bears on the rationality of state action that officials chose a peculiarly harsh method of achieving their ends while far more reasonable and effective means were at hand. Indeed, the *weighing* of alternatives is part of any responsible medical decision. But the *choice* among alternative treatments, provided that they meet reasonable standards, is properly one for the professional decision-maker to make.

This doctrine not only is consistent with constitutional principles but more closely approximates the realities of operating a facility for the retarded. Although state officials and courts must be sensitive to the liberty interests of retarded persons, see pages 5-6 *supra*, the fact remains that retarded persons are committed precisely because they cannot cope with liberty in the same way as other persons. *Addington* v. *Texas*, *supra*, 441 U.S. 427-30. The process of commitment itself depends on both a showing of mental retardation and some indication of an inability to remain at large. Once a retarded person has been confined, decision after decision will involve an assessment whether he can tolerate increased responsibility or must be subject to additional restrictions. Under these circumstances, the balance between liberty and restraint must have differing points of equilibrium.

We also question the idea that the provision of acceptable medical treatment within an institution may nonetheless violate the liberty interests of its residents. It is not unreasonable to suppose that a broad range of permissible treatment and restriction, left largely to the professional discretion of the staff, is inherent in the original commitment to a state facililty. Indeed, the due process safeguards preceding admission are intended to insure that these significant limitations are imposed only in proper cases. See *Addington* v. *Texas*, *supra*. Once admission has been legally authorized, however, it also stands to reason that conduct within that permissible, anticipated range does not amount to a constitutional violation. Under this view, only conduct falling below the acceptable standards, either because of the unusual severity of a particular isolated occurrence or because of a more systematic, repetitive abuse of basis standards, would infringe a constitutional right.

It can only trivialize constitutional rights to make civil rights actions a backup for unsuccessful malpractice suits. Although constitutional rights need not depend in kind or degree upon state rights, it nevertheless seems strained to say that committed patients may collect damages under the due process clause for a level of treatment about which most patients would have no legal complaint. The fact of state custody and lack of choice, which distinguish the committed person from other retarded persons, do not call for a different, basic standard of treatment, but rather for a searching inquiry into whether basic standards are being met. It is that inquiry, not one into the mysteries of least restrictive alternatives, that the courts should diligently make.

III. THIS COURT SHOULD MAKE CLEAR THAT LIABILITY MAY NOT BE IMPOSED WITHOUT FAULT FOR CONSTITUTIONAL TORTS.

The decision below also carries the implication that state employees will be held liable for constitutional violations over which they have little or no control. Although the Third Circuit appears to recognize a defense of good-faith immunity whenever "the official or employee was not aware, or had no reason to be aware, of [the particular constitutional] rights," Pet. App. 43a, that statement of the defense does not necessarily protect state employees at institutions that are understaffed or lack adequate facilities. These employees may simply be powerless to provide care and treatment at acceptable levels without additional funding. It is illogical, as well as inequitable, to hold them personally liable under such circumstances.

The inequity in this situation arises from several sources. In one sense, it stems simply from efforts to find a defendant to hold liable for violations of constitutional standards. Sovereign immunity shields the states from liability in damages for past wrongs, although they may be compelled to take corrective action in the future. See, e.g., *Edelman* v. *Jordan*, 415 U.S. 651 (1974). Thus, the courts must make do with whomever they can get before them, typically the individuals responsible for carrying out state efforts.

The problem is compounded by the awkward distinction between affirmative conduct and inaction. When government officials have taken affirmative action to deny someone his constitutional rights, by initating an unlawful search or seizure, or by ordering or participating in a physical attack, it is a relatively straightforward matter to find persons at fault. See, e.g., *Bivens* v. *Six Unknown Named Agents of the Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Scheuer* v. *Rhodes*,

416 U.S. 232 (1974). Implicit in this theory, however, is the idea that the defendant had an opportunity to respect constitutional rights and did not, an opportunity that is not in fact always open to state employees. Where steps must be taken to implement constitutional rights, there needs to be some recognition of the fact that a particular defendant cannot always take those steps himself.

The issue is one not of the wrong itself, but of responsibility for it. Unlike malpractice standards, which vary according to circumstances, it is not desirable to lower the substantive constitutional standards themselves to accommodate problems caused by lack of funding. To the extent that the state is responsible for indecent conditions, even if individual employees are not, the standards should be exacting enough to support an award of injunctive relief. See, e.g., *Ex Parte Young*, 209 U.S. 123 (1908). But the susceptibility of the state to an injunction should not mean that damages must be visited on its employees for institutional wrongs.

One solution to this problem is simply to recognize that the immunity defense encompasses not only ignorance of constitutional standards, but good-faith efforts to meet them. It is entirely possible, even likely, that state employees in mental hospitals or similar facilities may be acutely aware of their failure to meet constitutional standards but, at the same time, simply have no capacity to do much better. Whatever the law may require of state or federal *governments*, it makes little sense to insist, at pain of damages, that *individuals* do more than they possibly can do. At best, such a doctrine exacts relief from the wrong party; at worst, it will drive needed state employees to other jobs, further damaging the very institutions that plaintiffs seek to improve. See Note, *Psychiatry in the Public Sector*, 80 Hosp. & Comm. Psychiat. 749 *et seq.* (1974)

Another solution is to acknowledge that recovery for constitutional torts must depend upon a showing of fault. We see no reason for establishing a constitutional doctrine of *respondeat inferior*, penalizing employees for wrongs committed by their immune employer. To impose liability on a particular defendant, it is never enough simply for the plaintiff to prove that he suffered injury: he typically must show that his injury was actually caused by the particular defendant. The fact that the state has absolute immunity is not a basis for inventing a different rule here.

CONCLUSION

The judgment of the Court of Appeals should be vacated and the case remanded for a new trial in accordance with the principles set forth herein.

Respectfully submitted,

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